

## **EXHIBIT 2**

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## UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)

Step 1 and Step 2 Clinical Knowledge  
Applicant's Request for Test Accommodations

You MUST provide supporting documentation verifying your functional impairment. In order to document your need for accommodation as completely as possible, please attach:

- Evaluation reports of appropriate professionals printed on letterhead and signed by the evaluator(s)
- Primary documentation (report cards, teacher notes, behavioral observations, medical records, lab reports, etc.)
- A personal statement describing your disability and its impact on your daily life and educational functioning. Do not confine your comments to standardized test performance; rather discuss your overall functioning.
- Read documentation information on page 4.

Please note: NBME will acknowledge receipt of your request and audit your request for completeness. Submission of incomplete or illegible request forms and/or insufficient supporting documentation will slow the processing of your request. You may be asked to complete your request in a timely manner by submitting additional documentation.

Information regarding the granting or denial of test accommodations will not be released via telephone. All official communications regarding your request will be made in writing. Should you wish to modify or withdraw a request for test accommodations, please contact Disability Services at 215-590-9509.

Please type or print.

Accommodations are requested for the following Step examination (Use a separate form for each exam):

Step 1       Step 2 Clinical Knowledge       Step 2 Clinical Skills      Year:

## Section A: Biographical Information

1. Name: MAHMOOD      Last      MARIA      First      Middle Initial

2. Gender: Male      Female

3. Date of Birth:

4. SS#

(if known)

5. USMLE # 5-166-839-0

6. Address: 14717 EXBURY LANE  
 Street      LAUREL      City      MD      State/Province  
U.S.      Country      Zip/Postal Code 20707

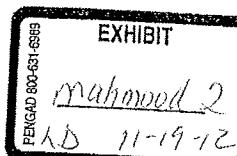
Daytime Telephone Number

RECEIVED      Alternate Telephone Number 7

APR 24 2007      E-mail address v

Disability Services Medical School: UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF MEDICINE

(Over)



**Section B: Nature of Disability**8. Indicate the **nature of the disability** and the year it was first professionally diagnosed (select all that apply):

## Sensory Impairments:

 Hearing Disability  Visual Disability 1988

## Learning Impairments:

 Reading Disability  Writing Disability Mathematics Disability  Other:

## Language Impairments:

 Receptive Language Disorder  Expressive Language Disorder Mixed Receptive/Expressive Language Disorder  Other:

## Medical Impairments:

 Mobility/Motor  Diabetes/Thyroid Dysfunction Epilepsy/Neurological  Other:

## Mental Health /Executive Function Impairments:

 Anxiety Disorder  Mood Disorders/ Depression Attention Deficit Hyperactivity Disorder  Other:**Section C: Accommodations Information**

10. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to the disability:

ADDITIONAL TESTING TIME (X2), PAPER EXAM, PERMISSION TO  
BRING ASSISTIVE DEVICE (MONOCULAR) INTO THE  
TESTING ROOM.

11. If you are requesting additional testing or break time, please indicate the amount of time requested (circle no more than one per Step).

## STEP 1:

Additional Break Time over 1 day  Additional Break Time over 2 days  
 Additional Testing Time – Time and one-half  Additional Testing Time – Double Time  
 Other (please specify):

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(Continued on the next page)

STEP 2:

Additional Break Time over 2 days       Additional Testing Time - Time and one-half  
 Additional Testing Time - Double Time  
 Other (please specify): \_\_\_\_\_

12. Do you require wheelchair access at the examination facility?

yes       no

If you require an adjustable height table, please indicate the number of inches from the floor:

**Section D: Accommodation History**

13. Prior classroom or test accommodations that you have received:

A. Standardized Examinations       yes       no

Medical College Admission Test (MCAT):

Month/Year AUGUST / 2002

Accommodation received ADDITIONAL TESTING TIME - DOUBLE TIME.

(If extra time, note amount given X2)

Other: SAT

Month/Year NOVEMBER / 1997

Accommodation received ADDITIONAL TESTING TIME

(If extra time, note amount given X2)

B. Medical School       yes       no

Accommodation received ADDITIONAL TESTING TIME - DOUBLE TIME

Date Approved AUGUST, 2004

If yes, have an appropriate official at your medical school complete the Certification of Prior Test Accommodations form.

C. College       yes       no

If yes, accommodations received ADDITIONAL TESTING TIME - DOUBLE TIME

D. Secondary or elementary school       yes       no

If yes, accommodations received ADDITIONAL TESTING TIME

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14. Authorization:

I authorize the National Board of Medical Examiners ( NBME) to contact the entities identified in Section D of this request form, and the professionals identified in the documentation I am submitting in connection with it, to obtain any or all of the following: confirmation, clarification, and/or further information. I authorize such entities and professionals to provide NBME with all requested confirmation, clarification, and further information.

Signature: Mark M. Mihnev Date: 03/15/07

**DO NOT SUBMIT:**

- Original documents; keep the original and submit a copy
- Research articles, resumes, curriculum vitas
- Handwritten letters from physicians or evaluators
- Handwritten letters from physicians or evaluators
- Documentation previously submitted to Disability Services
- Documentation previously submitted to your registration entity
- Previous correspondence from Disability Services
- Multiple copies of documentation (i.e., faxed and mailed copies of a document)
- Staples, clips, binders, page protectors, folders, or similar items

*Please note that submitting duplicate documentation and/or bound documentation may delay a decision regarding your request as all documentation must be processed.*

**DO SUBMIT:**

- Legible copies
- All documents in English. You are responsible for providing certified English translations of foreign-language documentation
- Typed or printed letters and reports from evaluators
- Documentation from childhood if you are requesting accommodations based on a developmental disorder, i.e. LD, ADHD, Dyslexia
- Documentation of your functional impairment in activities beyond test-taking
- Documentation of your functional impairment beyond self-report

Mail your completed questionnaire and documents to:

Students / Graduates of US & Canadian Medical Schools  
Testing Coordinator, Disability Services, National Board of Medical Examiners,  
3750 Market Street, Philadelphia, PA 19104-3190.  
215-590-9509

Students / Graduates of International Medical Schools  
Test Accommodations Coordinator, Educational Commission for Foreign Medical Graduates  
3624 Market Street, Philadelphia, PA 19104 USA.

Please keep a copy of your completed request form for your records.

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Disability Services